



*Embassy of the United States of America  
Oslo, Norway*

## **INSTRUCTIONS FOR MEDICAL EXAMINATION**

All immigrant visa applicants must undergo a medical examination in Norway.

**Applicants fifteen (15) years of age and older** must have a chest X-ray and a blood test in addition to a general medical evaluation. These tests must be performed at designated facilities in Norway. In addition the vaccination requirements explained below must be met.

**Applicants under fifteen (15) years of age** only need a general medical examination and necessary vaccinations, unless the examination reveals the need for additional tests.

### **Chest X-ray and Blood Tests**

The X-ray examination and the serological tests for syphilis and the HIV antibody must be done in Norway at the facilities specified in the accompanying documents. The chest X-ray examination and the serological (blood) test must be taken less than 90 days before your general medical examination by the panel physician. The results of the tests are sent directly to the panel physician - allow time for them to reach the panel physician before your appointment with him. The medical certificate from the panel physician's examination is only valid for six months, so it is important that you not schedule the examination too far in advance of your interview.

Each person having an X-ray and blood test **MUST PROVIDE PHOTO-IDENTIFICATION TO THE LABORATORY TECHNICIANS (PASSPORT PREFERRED.)**. Please have the technicians sign the enclosed sheet after having written down the photo-ID that was presented. **Give the completed sheet to the panel physician at the time of your physical examination.**

**To obtain the chest X-ray**, you must take the attached medical prescription form to any X-ray facility. If you plan to have your medical examination in Stavanger, please contact Dr. Cappelen Smith first before having your X-ray taken. The technician must send the results, including an evaluation, directly to the panel physician. **The technicians should mail the X-ray film/CD-ROM directly to panel physician. The CD-ROM should be placed in an envelope marked on the outside with the applicant's name, facility name and date of image exposure. The envelope must fully enclose the CD-ROM and be sealed.**

## HIV Blood Test

A blood test for the antibody to the Human Immunodeficiency Virus (HIV) is required as part of your medical examination for those 15 years or older. HIV is the virus that is the cause of the Acquired Immune Deficiency Syndrome (AIDS). AIDS is the name given to a group of illnesses that may occur in persons infected with HIV. Infection with HIV causes a defect in a person's natural immunity against disease. This defect leaves infected people vulnerable to serious illnesses that would not usually be a threat to anyone whose immune system was intact. This test is not to diagnose AIDS, and it does not necessarily mean that you have AIDS or will get it.

**To obtain the blood test**, you can go to your own physician or any laboratory, however you must use the prescription form from the panel physician, included with these instructions. Fill in your name, birth date, etc. The results should be returned directly by the laboratory to the panel physician at the address indicated. If the test for HIV is positive or inconclusive, it must be repeated so that a definite result is obtained.

The results of your test are provided to a consular officer. Also, it may be necessary to report results to health authorities in this country.

A positive test result means that you will not be eligible to receive a visa, but may be eligible for a waiver. A positive test result could also have other consequences on your day-to-day activities in this country.

## Vaccination Requirements

All immigrant visa applicants are required to obtain certain vaccinations prior to the issuance of the immigrant visa. You may need to have one or more of the vaccinations listed below, depending on your age. The panel physicians who conduct medical examinations of immigrant visa applicants are required to verify that applicants have met the vaccination requirements, or that it is medically inappropriate for the visa applicant to receive the required vaccinations. If born after 1956, Diphtheria/Tetanus (received during the last 10 years) and MMR are always required. The other listed vaccinations may be required for specific age groups. The panel physicians can give you more information. If you wish you can ask the nurse for details at the time of making the appointment.

*Mumps	*Measles	*Rubella	Human Papillomavirus (HPV)	Meningococcal
*Polio	Pertussis	Rotavirus	Tetanus and diphtheria toxoids	Hepatitis A
Hepatitis B	*Varicella	Zoster	Influenza type b (Hib)	

\* Contraindicated for pregnant women and immune-deficient individuals.

In order to assist the panel physician and avoid delays in the processing of an immigrant visa, **all immigrant visa applicants should have their vaccination records available for the panel physician to review** at the time of the immigrant medical examination. (Note: *if you wish, you may fax your vaccination records to the panel physician for review.*) Visa applicants should consult with their regular health care provider to obtain a copy of their immunization records, if one is available. If you do not have a vaccination record, the panel physician will work with you to determine which vaccinations you may need to meet the requirements. Certain waivers of the vaccination requirement are available upon the recommendation of the panel physician.

It is recommended that you have all vaccinations up-to-date before you see the panel physician. Although he can administer some vaccines, he does not have all of them in stock. The panel physician charges an extra fee for administering vaccines.

Only the panel physicians can determine which of the listed vaccinations are medically appropriate for you, given your age, medical history and current medical condition.

## **Making the Appointment**

The following doctors conduct medical examinations for the Embassy for visa purposes:

### **Oslo**

Dr. Torbjorn Haugen  
Dr. Thor Arne Grønnerød  
Ullevaal Stadion,  
Sognsveien 75F  
0855 Oslo

Tel: 22 02 68 33  
Fax: 22 02 68 11

### **Stavanger**

Dr. Christian Cappelen Smith  
Finnestadveien 28  
P. O. Box 110  
4001 Stavanger

Tel: 51 30 96 91  
Fax: 51 30 96 99  
Mobile No. 91 32 24 48  
Email: ccs@seadrill.com

For the physicians in Oslo: The answering machine is checked several times every day, Monday to Thursday. Leave a message and you will be contacted as soon as possible. Remember to give a telephone number or a fax number. Please use attached referral when doing blood test and X-ray.

For the physician in Stavanger: Please contact the doctor directly for referral to do blood test and X-ray. Reachable on mobile phone, email or fax, Monday to Friday. An appointment date will be given within 48 hours.

You must make an appointment to be examined, preferably BEFORE your visa interview. Because of the doctors' schedules, you should call to arrange the appointment date several weeks in advance of your visa interview at the Embassy. **Be sure to take your passport and the completed sheet signed by the x-ray and lab technicians to the examination.**

### **Fees**

You are liable for any and all examination fees. The physical examination fee is 2850 NOK for adults and 600 NOK for children under 15. There are separate fees for the chest X-ray and drawing blood for the serological tests, which are paid directly to the laboratories that do the work. These prices may be higher for non-residents of Norway. There are additional fees for vaccinations if you are required to have them; these vary depending on the particular vaccination(s) required.

If all tests are in order, the doctors will deliver the results to the Embassy in a few days. If you require expedited handling of your medical examination (i.e., the results sent to the Embassy in fewer than three days, or if the blood and X-ray results were not provided in advance and the results are needed quickly) the price of the examination doubles. The total examination fee for adults is then 5200 NOK and for children is 1200 NOK.

The panel physician forwards your completed medical examination results directly to the Embassy, and you will receive a confirmation of this in the mail.

**THE MEDICAL EXAMINATION - WHAT HAPPENS IN THE DOCTOR'S OFFICE?**  
**Legeundersøkelsen - Hva skjer på legekontoret?**

YOU WILL RECEIVE A MEDICAL DOCUMENT TO COMPLETE.  
YOU WILL PROVIDE A URINE SPECIMEN AT THE DOCTOR'S OFFICE.  
A CLINICAL MEDICAL EXAMINATION WILL BE PERFORMED.  
CERTAIN VACCINATIONS WILL BE GIVEN, IF NEEDED. (If available).  
THE MEDICAL DOCUMENT WILL BE SENT TO THE EMBASSY WHEN IT IS  
COMPLETED, AND YOU WILL RECEIVE A CONFIRMATION OF THIS IN THE MAIL.

--Du får utlevert det medisinske dokumentet som skal fylles ut.  
--Du må ta en urinprøve. Skal tas på lege-kontoret.  
--Det blir utført en klinisk legeundersøkelse.  
--Eventuelle vaksiner blir gitt. (Hvis tilgjengelig)  
--Det medisinske dokumentet sendes til ambassaden når det er ferdig, og du vil få  
en bekreftelse på dette i posten.

**REMEMBER TO BRING YOUR PASSPORT AND ONE PHOTO (I.E. ONE OF THE FOUR  
PHOTOS REQUIRED BY THE EMBASSY) FOR THE MEDICAL EXAMINATION.**

**Husk å ha med pass ved legeundersøkelsen, SAMT ET PASSBILDE (F.EKS. ET AV DE  
FIRE BILDENE AMBASSADEN KREVER).**

\*\*\*\*\*

**COST:** ADULT 2600 NOK, CHILDREN 600 NOK.  
MAY BE PAID IN CASH OR CREDIT CARD.  
ADDITIONAL VACCINATIONS. (CHECK WITH PHYSICIAN).  
**PRIS:** Voksne 2600 NOK, barn 600 NOK,  
Betales kontant eller med kontantkort.  
Tillegg vaksiner. (Kostpris).

\*\*\*\*\*

ANY QUESTIONS REGARDING THE MEDICAL DOCUMENTATION MUST BE  
DIRECTED TO THE DOCTORS.

Dersom du har spørsmål vedrørende den medisinske dokumentasjonen, skal dette rettes til  
legene, og ikke til ambassaden.

GOOD LUCK!!

Lykke til!!

Medical Examination in connection with application for visa to the U.S.  
*Medisinsk undersøkelse i forbindelse med visum til U.S.A.*

**IMPORTANT** - PLEASE READ THE ENCLOSED INFORMATION THOROUGHLY.  
**VIKTIG** - LES VEDLAGTE INFORMATIONSSKRIV NØYE.

**REMEMBER :**

*Husk:*

Check list

*Sjekkliste*

MAKE RESERVATIONS WITH THE DOCTOR WELL IN  
ADVANCE OF DEPARTURE.

*Bestill time hos legen i god tid før avreise.*

\_\_\_\_\_

ALL APPLICANTS OVER 15 YEARS MUST HAVE A BLOOD TEST  
AND A CHEST X-RAY.

*Alle søkere over 15 år må ta blodprøver og røntgenundersøkelse.*

\_\_\_\_\_

USE THE ENCLOSED LABORATORY REQUESTS. FILL IN NAME,  
DATE OF BIRTH AND ADDRESS.

*Kun vedlagte rekvisisjoner må benyttes. Fylles i med navn, fødselsdata  
og adresse.*

\_\_\_\_\_

X-RAYS MUST BE TAKEN IN A PUBLIC HOSPITAL OR ONE OF  
THE INSTITUTES NAMED ON THE LABORATORY REQUEST

*Røntgen må tas på offentlig sykehus, eller på institutt angitt på rekvisisjonen.*

\_\_\_\_\_

REMEMBER TO BRING IDENTIFICATION WITH PICTURE WHEN  
TAKING THE X-RAYS AND BLOOD TESTS. THE LAB TECHNICIANS  
MUST VERIFY YOUR IDENTITY ON THE ENCLOSED FORM WITH  
YOUR NAME FILLED IN.

*Husk ID med bilde ved røntgenundersøkelse og blodprøver.*

*Skal attesteres på eget skjema*

\_\_\_\_\_

PLEASE BRING PASSPORT, PHOTO, AND VACCINATION-CARD  
TO THE MEDICAL EXAMINATION.

*Ta med pass, bilde, og vaksinasjonskort ved legeundersøkelse.*

\_\_\_\_\_



## REQUEST FOR CHEST X-RAY AND SEROLOGIC TESTS

In order to meet the requirements for immigration to the United States of America,

\_\_\_\_\_ born on \_\_\_\_\_

in \_\_\_\_\_ must have a chest x-ray and serologic tests.

Please verify the identity of the person for whom you perform this service and indicate the type of identity document presented below.

X-Ray Technician:

The applicant identified himself/herself by means of:

\_\_\_\_\_ Passport No. \_\_\_\_\_

\_\_\_\_\_ Driver's License No. \_\_\_\_\_

\_\_\_\_\_ Other (specify) \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Stamp or Seal

Blood Technician:

The applicant identified himself/herself by means of:

\_\_\_\_\_ Passport No. \_\_\_\_\_

\_\_\_\_\_ Driver's License No. \_\_\_\_\_

\_\_\_\_\_ Other (specify) \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Stamp or Seal



# Radiologihenvising (Røntgenrekvisisjon)

Sentrum Røntgeninstitutt  
avd. Oslo/Lillestrøm

## PASIENT

Dr.med Torbjørn S. Haugen K.A.L Sognsveien 75F 0855 OSLO	Navn:	
	Fødselsnummer: (11siffer)	
	Adresse/ tlf./helst mobil:	
	Postnr./sted:	

Kliniske opplysninger

Kopi av svar  
bes sendt til:

Us. før emigr. til USA, spes. tbc. ønskes sikrest mulig utelukket, hvorfor rtg. er obligatorisk. OBS: Pas. identitet må kontr.(bilde-ID) og bekreftes på eget skjema. Denne rekv. gjelder også for u.s. ved alle off. sykehus. CD legges i en forseilet konvolutt med søkerens navn og dato for u.s.  
Denne, sammen med beskrivelsen sendes til rekvirerende lege.

Hva ønskes undersøkt:  
RTG THORAX

Fylles ut av henvisende lege

Sett kryss:

JA

NEI

Jeg bekrefter at us. rekvireres pga. sykdom, skade, lyte eller mistanke om sykdom (Hvis NEI: pasienten eller annen debitor betaler hele undersøkelsen)

09/01/09

Dr.med Torbjørn S. Haugen

Jeg ber om at radiologen endrer modalitet (us. metode) og evt. foretar supplerende undersøkelser hvor dette er medisinsk indikert

HEKV. DATO

SREKV. LEGESUNDERSØKELSE FORVAY

RADIOGRAF

KODER FOR UNDERSØKELSDATO/DIA. NORAKO/ABRACO

GRAVID?: JA

NEI

RADIOLOG

Sentrum Røntgeninstitutt  
avd. Oslo/Lillestrøm:

**OBS!** Avd. i Storgt. 8 er flyttet til Oslo City, Stenersgt. 1A fra nov. 2005. (inngang til venstre for kjøpesenteret Oslo Citys hovedinngang).

Oslo City, Stenersgt. 1A, 0050 Oslo

Timebestilling: 23 35 56 00

Telefax: 23 35 56 10

Kr. Augusts gt. 19, 0164 Oslo

Timebestilling: 23 32 76 00

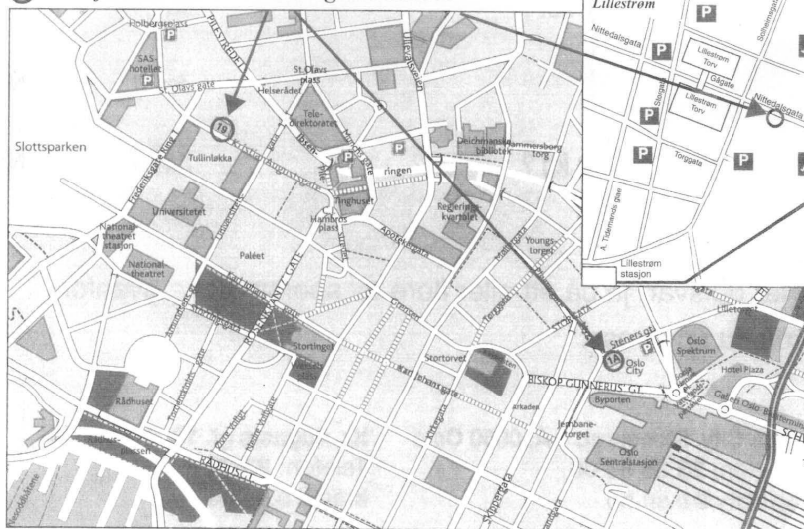
Telefax: 22 36 06 61

Nittedalsgt. 2 B, 2000 Lillestrøm

Timebestilling: 63 89 84 44

Telefax: 63 80 27 03

Her finner du oss i Oslo og Lillestrøm



Time er bestilt  
og avtalt til:

Avdeling	Dag	Dato	Klokken

Mer informasjon finner du på:  
[www.serinn.no](http://www.serinn.no)



ULLEVÅL SYKEHUS  
MIKROBIOLOGISK AVD.

0407 Oslo  
Tlf. 22 11 88 25

MÅ FYLLES UT

REKVIRENT

Navn

Torbjørn S. Haugen

Avd./sykehus

Klinikk for allergi og lunges.

Adresse

Sognsvn. 75

Postnr/poststed

0855 OSLO

Rekvirent kode

2106191

Tlf.

22026810

PASIENT

Fødselsdato og personnummer

Innlagt

☐ Ja ☒ Nei

Etternavn

Fornavn

Postnr. og bostedsfylke

Referansenummer for  
elektronisk pasientkobling

PROBLEMSTILLING/KLINISKE OPPLYSNINGER

Obligatorisk us før emigrasjon til USA, der immunstatus kreves.  
OBS: Vennligst kontroller pasientens identitet (bilde-ID) og bekreft  
dette på eget skjema.

Antimikrobiell terapi ☐ Nei ☐ Ja Fra ..... til ..... Medikament(er): .....

PRØVEMATERIALE tatt dato: .....

kl. ....

- ☐ Urin, midtstrømsprøve
- ☐ Urin, samlepose fra barn
- ☐ Urin, engangskateterisering
- ☐ Urin, permanent blærekateter
- ☐ Urin, blærepunksjon

- ☐ Halsprøve
- ☐ Neseprøve
- ☐ Nasofarynxaspirat
- ☐ Ekspektorat
- ☐ Trakealsekret
- ☐ Larynxpensel
- ☐ Bronkialsekret
- ☐ Bronkialsykylvæske (BAL)

- ☐ Blodkultur
- ☐ Spinalvæske
- ☐ Leddvæske
- ☐ Pleuravæske
- ☐ Ascitesvæske
- ☐ Dialysevæske

- ☐ Sårsekret
- ☐ Puss
- ☐ Vesikkel
- ☐ Biopsi/autopsi
- ☐ Intravasalt kateter

- ☐ Øreprøve
- ☐ Øyepøve
- ☐ Fæces i bakt.  
transportmedium
- ☐ Fæces tilsatt 5-10 ml  
4% formalin  
(for parasitt u.s.)
- ☐ Fæces uten tilsetning
- ☐ .....
- ☐ .....

- ☐ Cervixprøve
- ☐ Urethraprøve
- ☐ Vaginalprøve
- ☐ Anusprøve

☐ Morsmelk

- ☐ Hudavskrap
- ☐ Neglimateriale
- ☐ Hår

☒ Blod/Serum  
til serologi

Lokalisasjon/nærmere beskrivelse: .....

ØNSKET UNDERSØKELSE

AGENS PÅVISNING

- ☐ Alm. bakteriologisk u.s.
- ☐ Bare beta-hemolytiske streptokokker
- ☐ Mykobakterier (tb)
- ☐ Kikhostebakterier
- ☐ Gjærsopp
- ☐ Dermatofytter
- ☐ .....
- ☐ .....
- ☐ .....
- ☐ Gonokokker
- ☐ Tarmpatogene bakterier
- ☐ Parasitter
- ☐ Cl.difficile toxin  
(i fæces uten tilsetning)
- ☐ Chlamydia trachomatis
- ☐ Herpes simplex virus
- ☐ Luftveisvirus
- ☐ Andre virus: .....
- ☐ .....
- ☐ .....

SEROLOGI

☐ Aktuell sykdom ☒ Immunitetsstatus

1. sykdomsdag/sykdomsvarighet: .....

Er prøve sendt tidligere: ☒ Nei ☐ Ja Når? .....

- ☐ Mycoplasma pneumoniae
- ☐ Chlamydia sp.
- ☐ Influenzavirus
- ☐ Epstein Barr virus/  
mononukleose
- ☐ Cytomegalovirus
- ☐ Hepatitt A virus
- ☐ Hepatitt Bs antigen
- ☐ Hepatitt Bs antistoff
- ☐ Hepatitt C virus
- ☒ HIV
- ☐ .....
- ☐ Rubellavirus
- ☐ Varicella/zoster virus
- ☐ Parvovirus
- ☐ (Erythema infectiosum)
- ☐ Parotittvirus
- ☐ Morbillivirus
- ☐ AST
- ☐ Yersinia
- ☒ Syfilis
- ☐ Borrelia
- ☐ Toxoplasma
- ☐ .....
- ☐ .....

Laboratoriet velger av og til undersøkelser på grunnlag av de kliniske opplysninger og den epidemiske situasjon.

Dato ..... Legens underskrift ..... Torbjørn S. Haugen



<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> FLU. A/FLU. B KBR	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> EBV
<input type="checkbox"/> MYC/ORNI KBR	<input type="checkbox"/> WIDALS REAKSJON
<input type="checkbox"/> MYC/ORNI/AD KBR	<input type="checkbox"/> YERSINIA O3
<input type="checkbox"/> RESP.VIRUS KBR	<input type="checkbox"/> AKUTTFASEPRØVE
<input type="checkbox"/> ADENOVIRUS KBR	<input type="checkbox"/> INFLUENZA B KBR
<input type="checkbox"/> CHLAMYDIA KBR	<input type="checkbox"/>
<input type="checkbox"/> COXSACKIE B KBR	<input type="checkbox"/> MORBILLVIR. KBR
<input type="checkbox"/>	<input type="checkbox"/> MYCOPL.PNEU. KBR
<input type="checkbox"/> GONOKOKK KBR	<input type="checkbox"/> PARAINFLUEN. KBR
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> INFLUENZA A KBR	<input type="checkbox"/>
<input type="checkbox"/> HEPATITT B C AS	<input type="checkbox"/>
<input type="checkbox"/> HEPATITT B E AG	<input type="checkbox"/>
<input type="checkbox"/> HEPATITT B E AS	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ANTI DNASE B	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> TPPA SERUM
<input type="checkbox"/>	<input type="checkbox"/> TPPA SPINALV.
<input type="checkbox"/> MORBILLI IGM	<input type="checkbox"/> PARVO B19 IGM

- |  |   |
|--|---|
| <input type="checkbox"/>                   | <input type="checkbox"/>                  |
| <input type="checkbox"/>                   | <input type="checkbox"/>                  |
| <input type="checkbox"/> FLU. A/FLU. B KBR | <input type="checkbox"/>                  |
| <input type="checkbox"/>                   | <input type="checkbox"/> EBV              |
| <input type="checkbox"/> MYC/ORNI KBR      | <input type="checkbox"/> WIDALS REAKSJON  |
| <input type="checkbox"/> MYC/ORNI/AD KBR   | <input type="checkbox"/> YERSINIA O3      |
| <input type="checkbox"/> RESP.VIRUS KBR    | <input type="checkbox"/> AKUTTFASEPRØVE   |
| <br>                                       |   |
| <input type="checkbox"/> ADENOVIRUS KBR    | <input type="checkbox"/> INFLUENZA B KBR  |
| <input type="checkbox"/> CHLAMYDIA KBR     | <input type="checkbox"/>                  |
| <input type="checkbox"/> COXSACKIE B KBR   | <input type="checkbox"/> MORBILLVIR. KBR  |
| <input type="checkbox"/>                   | <input type="checkbox"/> MYCOPL.PNEU. KBR |
| <input type="checkbox"/> GONOKOKK KBR      | <input type="checkbox"/> PARAINFLUEN. KBR |
| <input type="checkbox"/>                   | <input type="checkbox"/>                  |
| <input type="checkbox"/> INFLUENZA A KBR   | <input type="checkbox"/>                  |
| <br>                                       |   |
| <input type="checkbox"/> HEPATITT B C AS   | <input type="checkbox"/>                  |
| <input type="checkbox"/> HEPATITT B E AG   | <input type="checkbox"/>                  |
| <input type="checkbox"/> HEPATITT B E AS   | <input type="checkbox"/>                  |
| <input type="checkbox"/>                   | <input type="checkbox"/>                  |
| <input type="checkbox"/> ANTI DNASE B      | <input type="checkbox"/>                  |
| <input type="checkbox"/>                   | <input type="checkbox"/> TPPA SERUM       |
| <input type="checkbox"/>                   | <input type="checkbox"/> TPPA SPINALV.    |
| <br>                                       |   |
| <input type="checkbox"/> MORBILLI IGM      | <input type="checkbox"/> PARVO B19 IGM    |

- |  |   |
|--|---|
| <input type="checkbox"/> CYTOMEG.VIR. IGG  | <input type="checkbox"/> HEPATITTT A IGG    |
| <input type="checkbox"/> CYTOMEG.VIR. IGM  | <input type="checkbox"/> HEPATITTT A IGM    |
| <input type="checkbox"/> HERPESVIRUS IGM   | <input type="checkbox"/> HEPATITTT B S SG   |
| <input type="checkbox"/> RUBELLAVIR. IGG   | <input type="checkbox"/> HEPATITTT B S AS   |
| <input type="checkbox"/> RUBELLAVIR. IGM   | <input type="checkbox"/> HEPATITTT C AS     |
| <input type="checkbox"/> VARIC./ZOST. IGG  | <input type="checkbox"/> LUES REAGIN SER    |
| <input type="checkbox"/> HIV AS            | <input type="checkbox"/> LUES REAGIN SPV    |
| <br>                                       |   |
| <input type="checkbox"/> RESP.SYNC. V. KBR | <input type="checkbox"/> AMØBE AS           |
| <input type="checkbox"/> ROTAVIRUS KBR     | <input type="checkbox"/>                    |
| <input type="checkbox"/> VARIC./ZOST. KBR  | <input type="checkbox"/> LEISHMANIA AS      |
| <input type="checkbox"/>                   | <input type="checkbox"/> MALARIA AS         |
| <input type="checkbox"/> FILARIA AS        | <input type="checkbox"/>                    |
| <input type="checkbox"/> HIV AG            | <input type="checkbox"/> SCHISTOSOMA AS     |
|  | <input type="checkbox"/>                    |
| <br>                                       |   |
| <input type="checkbox"/> BORRELLIA SER HA  | <input type="checkbox"/>                    |
| <input type="checkbox"/> BORRELLIA SPV HA  | <input type="checkbox"/>                    |
| <input type="checkbox"/> MYCOPL. PNEU. IGM | <input type="checkbox"/> PAROTITTTYVIR. IGM |
| <input type="checkbox"/>                   | <input type="checkbox"/> TOXO GONDII IGG    |
| <input type="checkbox"/>                   | <input type="checkbox"/> TOXO GONDII IGM    |
| <input type="checkbox"/>                   | <input type="checkbox"/> HIV P24 AS         |
| <input type="checkbox"/>                   | <input type="checkbox"/> HIV GP41 AS        |

- ☐ HEPATITIT A IGG
- ☐ HEPATITIT A IGM
- ☐ HEPATITIT B S SG
- ☐ HEPATITIT B S AS
- ☐ HEPATITIT C AS
- ☐ LUES REAGIN SER
- ☐ LUES REAGIN SPV
  
- ☐ AMØBE AS
- ☐
- ☐ LEISHMANIA AS
- ☐ MALARIA AS
- ☐
- ☐ SCHISTOSOMA AS
- ☐
  
- ☐
- ☐
- ☐ PAROTITITVIR. IGM
- ☐ TOXO GONDII IGG
- ☐ TOXO GONDII IGM
- ☐ HIV P24 AS
- ☐ HIV GP41 AS

- AMPICILLIN  
AZLOICILLIN  
AZTREONAM  
BACITRACIN  
CEFALEXIN  
CEFALOTIN  
CEFOTAXIM  
CEFOXITIN  
CEFTAZIDIM  
CEFUROXIM  
CIPROFLOXACIN  
CLINDAMYCIN  
CLOXACILLIN  
DOXYCYCLIN  
ERYTHROMYCIN  
FUCIDIN  
GENTAMICIN  
IMPENEM  
KLORAMFENIKOL  
MECILLINAM  
METRONIDAZOL  
NALIDIXIN  
NETILMICIN  
NITROFURANTOIN  
OXYTETRACYCLIN  
PENICILLIN-G  
PENICILLIN-V  
SULFA-TRIMET  
SULFAGRUPPEN  
TOBRAMYCIN  
TRIMETOPRIM  
VANCOMYCIN

[illegible]